Language skills of UBC medical students: Working toward cultural competency in health care

Though medical students have non-English language skills that accurately reflect the diversity of languages spoken in British Columbia, they would not feel comfortable using those languages in a clinical encounter.

Tung Siu, MASc, Mandeep Mann, MSc, Birinder Mangat, BSc, Brock Rawstron, BSc, Shafik Dharamsi, PhD

ABSTRACT: As Canada becomes increasingly diverse, the medical community is recognizing the unique challenges of providing health care for patients with different linguistic and cultural backgrounds. A single-page survey was administered to assess the language skills of first- and second-year medical students at the University of British Columbia. More than a quarter of the respondents are fluent in a language other than English as their first language. More than half of the respondents speak one or more languages other than English at a moderate to advanced level. Despite demonstrated ability and interest, a majority of medical students who are fluent in another language do not consider themselves proficient enough to communicate about medical issues with a patient in that language. Bridging this discrepancy will ensure that the health care needs of our multicultural population are better met.

Mr Siu, Ms Mann, Ms Mangat, and Mr Rawstron are students in the University of British Columbia MD undergraduate program. Dr Dharamsi is assistant professor in the Department of Family Practice and associate director of the Centre for International Health at the University of British Columbia.

Background

British Columbia is home to a culturally diverse population. In BC, 24.5% of the population belongs to a visible minority. Twenty-nine percent of British Columbians have a non-English first language and 16.5% of us speak a non-English language at home. Furthermore, 3.1% of BC's population reports that they have no knowledge of English.[1] Therefore, cultural competence is an important and essential capability for physicians to provide care to a substantial portion of our society.

To be culturally competent means that physicians have developed the knowledge, skills, and approaches to patient care that enables them to function effectively and to respond appropriately and sensitively in cross-cultural settings.[2] As the Canadian population becomes increasingly diverse, the medical community is recognizing the unique challenges of providing health care for patients with different linguistic and cultural backgrounds. Medical students must be trained to be aware of cultural nuances in clinical encounters in order to optimize rapport and, thus, to individualize the assessment and management of patients. The Medical Council of Canada has recognized this need and has outlined sociocultural competency as an objective to be met through the Licentiate of the Medical Council of Canada examination.[3] Indeed medical schools are working toward improving cultural sensitivity training, but greater effort is needed.[4,5]

Language is an often overlooked capacity that has the potential to bridge the cultural gap and enhance the doctor-patient relationship. Identifying and encouraging the development of language skills in medical students might be the key to fostering more culturally competent physicians. As an initial step toward that goal, a survey was conducted in order to assess the language skills of UBC medical students and their ability to communicate with patients who speak a non-English language in a clinical setting.

Methods

A single-page, original eight-question anonymous survey (see Figure) was administered to assess the language skills of first- and second-year medical students (classes of 2011 and 2010) at UBC. The survey was distributed in paper format during the Doctor, Patient, and Society (DPAS) class on the first day of the academic year. The survey and analysis were carried out as part of a student-directed project in the DPAS course. The data were analyzed in Microsoft Excel by eight second-year medical students.

Results

In total, 237 of 301 students in first year and 177 of 261 students in second year chose to take part in the survey. The total number of students includes 40 dental students in each year because of the combined medical and dental curriculum at UBC. The responses from the medical and dental

DPAS 420 Independent Project — Language Survey

Instructions: Please circle your answer choices or write out the name of the languages.

1) Which class are you in?

I am in the Class of:	2010	2011

2) What is your first language (i.e. first language learned as a child)?

Cantonese	Farsi	French	Hindi
Korean	Mandarin	Punjabi	Spanish
English	Please list others:		

3) What is your home language (i.e. language spoken most often at home)?

Cantonese	Farsi	French	Hindi
Korean	Mandarin	Punjabi	Spanish
English	Please list others:		

4) What are the languages (other than English) that you speak at a moderate-advanced level (i.e. conversational to proficient)?

Cantonese	Farsi	French	Hindi
Korean	Mandarin	Punjabi	Spanish
None	Please list others:		

5) What are the languages (other than English) that you speak at a basic level (i.e. in broken phrases)?

Cantonese	Farsi	French	Hindi
Korean	Mandarin	Punjabi	Spanish
None	Please list others:		

6) Please rate your ability to communicate with patients using languages (other than English) that you speak at a moderate-advanced level?

Languages	None (Not comfortable at all)	Limited (will take too long to be practical)	Moderate (can take a limited Hx and explain a common Dx)	Proficient (like I am speaking English)
1)	None	Limited	Moderate	Proficient
2)	None	Limited	Moderate	Proficient
3)	None	Limited	Moderate	Proficient
4)	None	Limited	Moderate	Proficient

7) For your own career in medicine, please rate how important it is for you to be able to communicate competently with patients who do not speak English (either through translation services or a language that you speak proficiently)?

No use at all	Would be nice but not a priority	Would be helpful	Very important

8) Would you be interested in receiving resources / attending workshops to learn about medical terminology in different languages? Yes No
If "Yes", which languages?

Figure. Survey carried out as part of a student-directed learning project in the DPAS course in the UBC MD undergraduate program.

Dean's commentary

We asked the dean to comment on "Language skills of UBC medical students: Working toward cultural competency in health care." Here is his commentary. —ED

Aspects of multiculturalism as related to the practice of medicine are especially relevant to British Columbia and Canada, and are therefore considered in two courses (Doctor, Patient and Society Years I and II) within the UBC Faculty of Medicine Undergraduate Medical Program. Completion of these courses requires (among other topics) that students be aware of gender and culture biases, including that of language, in self and others and also that there is a recognition of how racial/ethnic differences can affect health care delivery.

In the most recent Accreditation Report about the Faculty of Medicine at UBC (March 2008), the site team found a high level of satisfaction with the evaluation system of the course (3.83/5.00 in the class of 2010 for the Year I course) and that as students matured they "gained a greater appreciation [of the practice of medicine within a complex, diverse, and multicultural society], and had more exposure to clinical practice."

As is the case for all aspects of curriculum renewal, the contents of the total curriculum are reviewed on an ongoing basis and we are currently undertaking an in-depth review of the curriculum, which will no doubt include issues of cultural safety. The undergraduate curriculum is only the beginning of what is a lifelong learning approach to becoming culturally aware in order to provide the best clinical care in a patient-centred context.

—Gavin Stuart, MD
Dean, Faculty of Medicine, UBC

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Table. Percentage of respondents who speak a particular language other than English at a moderate to advanced level.

	Class of 2010	Class of 2011
Cantonese	13%	9%
Farsi	4%	3%
French	22%	23%
Hindi	3%	3%
Korean	2%	2%
Mandarin	8%	5%
Punjabi	6%	5%
Spanish	5%	5%
Vietnamese	1%	0%
German	2%	3%
Italian	1%	1%
Russian	1%	1%
Japanese	1%	3%
Other	7%	7%

students were not differentiated. The response rate was 78.7% and 66.8% for first and second year respectively. Twenty-seven percent of the first-year class and 31% of the second-year class have a language other than English as their first language. The four most spoken first languages for both classes were in similar ranges and rank order—respectively for the first- and second-year classes those were Cantonese (8% and 12%), Mandarin (3% and 5%), Farsi (3% and 4%), and Punjabi (3% in both).

In terms of language spoken most often at home, 22% and 29% of the first- and second-year class, respectively, speak a language other than English. With regard to the current language skills of UBC medical students, 54% and 59% of the first- and second-year class speak one or more languages other than English at a moderate to advanced level (defined as conversational to proficient) (Table). Of the students who speak a language other than English fluently (moderate to advanced level), only 24% feel they are proficient enough to communicate with a patient in that language.

When asked how important it is for them to be able to communicate competently (defined in the survey as "speaking proficiently in the language or using a translation service") with patients who do not speak English, 89% of all students rated that skill to be either "helpful" or "very important." The remainder rated it as "nice, but not a priority" or "no use at all."

Further, when asked if they would like to attend workshops aimed at improving language and cross-cultural skills, many students expressed great interest in the option; 72% of the first-year class and 62% of the second-year class suggested they would attend such workshops. As such, it is clear that if cross-cultural and medical language skills training were included in the curriculum or as extracurricular activities, it would be useful and appreciated by the majority of students from UBC medical school.

Limitations

There are a number of limitations to our study. The study sample was drawn from undergraduate medical students from a single Canadian province and is not necessarily representative of medical students from other provinces and countries. The study also relied on the self-reported information of individual survey respondents. The questions were few in number and had limited content. The objective of the survey was to gather baseline information. Therefore, the decision was made to limit the number and content of the questions, with the intent to follow this survey with another in-depth survey at a later time.

Conclusions

A similar percentage of UBC medical students and BC's population speak a non-English first language. Furthermore, a higher percentage of UBC medical students speak a non-English language at home compared with BC's population. Despite the clearly demonstrated ability and interest, a majority of medical students who were fluent in a non-English language did not consider themselves proficient enough to communicate with a patient in that language. It is likely that students lack the basic medical terminology/vocabulary in their non-English languages and, as such, feel unqualified to communicate effectively with their patients. This suggests that students who are fluent in a language may not feel fluent in a medical setting and may need additional training in order to effectively use their language skills.

Students may need additional training in order to effectively use their language skills.

As expected, a majority of the medical students felt that effective communication would be an important part of patient care. The survey results indicate that there is a need to teach students medical terminology in different languages in order for them to utilize their multilingual skills for the benefit of patients. This could be accomplished by conducting student-directed language workshops similar to those run by the Students for Cross-Cultural Health Care (SCCHC) group at UBC.[6] In these sessions, resources were provided as well as opportunities to practise medical language skills with a native speaker. Other sessions may be devoted to conducting interviews with a translator or bridging the cultural divide with basic language and cultural understandings. We believe that enhancing cultural and linguistic skills in medical students is a constructive step toward preparing future physicians to meet the sociocultural competency mandated by the

Medical Council of Canada and, most importantly, providing culturally sensitive health care for our multicultural population.

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BCMA AGM: 13 June 2009

The BCMA's 2009 Annual General Meeting and Convention will be held in Vancouver on Saturday, 13 June 2009, at the Sheraton Vancouver Wall Centre Hotel. Please contact Ms Lorie Janzen with any related questions at ljanzen@bcma.bc.ca or go to the BCMA web site at www.bcma.org for updates.

Autism centre for assessment, diagnosis, and treatment

Monarch House Autism Centre (www.monarchhouse.ca) was created by CBI Health Group to be a centre of excellence offering a multidisciplinary, integrated team approach for programming and intervention for children with ASD and other developmental disabilities. Monarch House has occupational therapists, speech and language pathologists, psychologists, and pediatricians all under one roof. The centre's goal is to simplify the journey parents have to take from questions to interventions around ASD and other developmental disabilities. Their intervention services include:

- Applied behavior analysis-based programs.
- Sensory integration.
- Communication-based interventions.

Monarch House is located at 3185 Willingdon Green, in Burnaby, and is now evaluating children for programming, intervention, and support needs. To learn more, schedule a meeting, or request a tour, call Alaric de Souza, director of operations, at 604 205-9204, or e-mail adesouza@cbi.ca.

World Health Day challenge: Donate a day for Africa

This year on World Health Day (7 April), consider "donating a day" for Africa, Canadian Physicians for Aid and Relief's (CPAR's) 4th Annual World Health Day Challenge. By donating part or all of 1 day's income, you'll demonstrate your commitment to improving health in Africa.

The World Health Day Challenge is partly inspired by the efforts of Dr Kevin Wade, a Vancouver-based ophthalmologist who donated a day of his medical service payment plans to CPAR in September 2002 and again in September 2005.

"When I saw CPAR's work firsthand and experienced the health conditions in Malawi during a research project, I knew I wanted to contribute to the cause," says Dr Wade.

"My responsibilities in Canada to my patients, staff, and family make working in Africa difficult, so I think that donating a day's office income is another way I can help out."

CPAR's primary health care work focuses on reducing the burden of HIV and AIDS through community-awareness programs, preventing the spread of common diseases by increasing access to clean water and sanitation facilities, promoting healthy pregnancies, and educating communities about sexual and reproductive health issues. Founded in 1984, CPAR works in partnership with vulnerable communities and diverse organizations to overcome poverty and build healthy communities in Ethiopia, Tanzania, Uganda, and Malawi.

Physicians and other supporters can donate at www.donateaday.ca.